

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/28/2012
NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00113380.</p> <p>Complaint IN00113380- Unsubstantiated due to lack of evidence.</p> <p>Survey date: August 28, 2012</p> <p>Facility number: 000280 Provider number: 155707 AIM number: 100274540</p> <p>Surveyor: Randall Fry RN</p> <p>Census bed type: SNF: 35 SNF/NF: 76 Residential: 78 Total: 189</p> <p>Census payor type: Medicare: 11 Medicaid: 50 Other: 128 Total: 189</p> <p>Residential Sample: 5</p> <p>Swiss Village Incorporated was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00113380.</p> <p>Quality review completed on August 29, 2012 by Bev Faulkner, RN</p>	R 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

DX2Q11

If continuation sheet 1 of 1